STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055457	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Healthcare & Rehabilitation Center	12627 Studebaker Road Norwalk, CA 90650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect two of three sampled residents (Resident 1 and Resident 2) when: 1. Certified Nursing Assistant (CNA) 1 reported to Licensed Vocational Nurse (LVN) 3 that Resident 2 accused her (CNA1) of abuse on 3/1/2026. CNA 1 was reassigned to another area in the facility away from Resident 2 and on 3/2/2026 she was assigned to care for two residents who were Resident 2's roommates instead of suspending CNA 1 and removing her from the facility. 2. Registered Nurse (RN) 1 reassigned LVN 1 to care for other residents in the facility instead of suspending her and removing her from the facility when she was made aware of an allegation that LVN 1 inappropriately touched Resident 1. These deficient practices resulted Resident 1, Resident 2, and other residents' who resided in the facility being unprotected while CNA 1 and LVN 1 remained on the facility premises after being accused of abuse. These deficient practices placed Resident 1, Resident 2 and other residents' who resided in the facility at risk for abuse.Findings: a. During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 2 had diagnoses including primary essential hypertension ([HTN] high blood pressure), peripheral vascular disease ([PVD] a slow progressive narrowing of the blood flow to the arms and legs), and hypothyroidism (a deficiency of the hormone causing the body to slow down). During a review of Resident 2's Minimum Data Set Assessment ([MDS] a resident assessment tool) dated 2/4/2026, the MDS indicated Resident 2's cognition (ability to think and reason) was intact. Resident 2 required set up or clean up assistance to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) During a review of Resident 2's Care Plan dated 6/19/2024, the Care Plan indicated residents and/or their responsible party were made aware the facility identifies abuse, practices and omissions that lead to abuse, neglect, and misappropriation of property. The goal of the Care Plan was for the facility to promptly identify and take appropriate measures to protect residents' from abuse. The Care Plan's interventions included immediate suspension of the employee if they were identified as the aggressor, escort them out of the facility and to notify the abuse coordinator as soon as the allegation of abuse was made (within 15 minutes of occurrence). During a review of Resident 2's Change of Condition (COC)/Interact Assessment form ([SBAR] situation, background, assessment, recommendation, a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/2/2026 and timed at 1 p.m., the COC/SBAR indicated Resident 2 reported CNA 1 was rough with her, grabbed her wrist and twisted her arm, so she (Resident 2) tried to kick CNA 1 to get away from her. During an interview on 3/9/2026 at 9:56 a.m., Resident 2 stated, via CNA 1, who translated for Resident 2, on 3/1/2026 (time unknown) she was in bed and CNA 1 came to her room in a bad mood, grabbed her left arm tight and pressed her fingers into her left ankle hard. Resident 2 stated she did not think to tell anyone. During an interview on 3/9/2026 at 12 p.m., CNA 1 stated on 3/1/2026 she went into Resident 2's room to change her adult brief. Resident 2 was in bed, and she (CNA 1) rolled her from left to right while putting the adult brief on her. Resident 2 got upset and accused her (CNA 1) of grabbing her left arm (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and abusing her. CNA 1 stated she left the room and told LVN 3 that Resident 2 accused her of abuse. CNA 1 stated she was reassigned to another resident and CNA 2 took over her assignment with Resident 2. The next day (3/2/2026) during the 7 a.m. to 3 p.m. shift, she was not assigned to care for Resident 2 but was assigned to care for two residents who shared a room with Resident 2. CNA 1 stated when she went to the room to care for the two residents assigned to her, Resident 2 started cursing at her and blocking the doorway with her wheelchair to keep her from entering the room. During an interview on 3/9/2026 at 12:17 p.m., CNA 2 stated she worked with CNA 1 on 3/1/2026 when Resident 2 accused her (CNA 1) of abuse. CNA 2 stated she was standing with CNA 1 when CNA 1 reported the allegation of abuse made by Resident 2 to LVN 3. During an interview on 3/9/2026 at 12:30 p.m., LVN 3 stated CNA 1 told her on 3/1/2026 that Resident 2 called her the B word and that Resident 2 was being aggressive towards her (CNA 1) so she changed CNA 1's assignment and assigned CNA 2 to care for Resident 2. On 3/2/2026 (time unknown) Resident 2 told her about CNA 1 twisting her left arm on 3/1/2026. LVN 3 stated on 3/2/2026 CNA 1 was not assigned to care for Resident 2 instead she was assigned to care for two other residents who occupied the room with Resident 2. During an interview on 3/9/2026 at 3:45 p.m., RN 2 stated she did not recall CNA 1 telling her that Resident 2 accused her of abuse on 3/1/2026, she remembered CNA 1 requesting to be removed from her assignment with Resident 2 and Resident 2 not wanting CNA 1 to care for her anymore. RN 2 stated she did not ask CNA 1 why she did not want to care for Resident 2 anymore, and she did not ask Resident 2 why she did not want CNA 1 to care for her, she just asked LVN 3 to change CNA 1's assignment. b. During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1 had diagnoses including aphasia (a disorder that makes it difficult to speak) following a cerebral infarction (where blood flow to the brain has been blocked). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1's cognition was severely impaired. Resident 1 was dependent (helper does all the effort) on staff to complete his ADLs. During a review of Resident 1's Care Plan dated 1/15/2026, the Care Plan indicated residents and/or their responsible party were made aware the facility identifies abuse, practices and omissions that lead to abuse, neglect, and misappropriation of property. The goal of the Care Plan was for the facility to promptly identify and take appropriate measures to protect residents' from abuse. The Care Plan's interventions included immediate suspension of the employee if they were identified as the aggressor, escort them out of the facility and to notify the abuse coordinator as soon as the allegation of abuse was made (within 15 minutes of occurrence). During a review of Resident 1's COC/SBAR dated 3/5/2026 and timed at 11:58 a.m., the COC/SBAR indicated during the Interdisciplinary Team meeting ([IDT] a group of health care professionals with various areas of expertise who work together toward the goals of the residents) Resident 1's Family Member (FM) accused LVN 1 of lifting Resident 1's sheet, touching Resident 1's diaper, then LVN 1 placed the sheet back over Resident 1 and walked out of the room during the 11: p.m. - 7 a.m. shift on 3/4/2026. During an interview on 3/6/2026 at 10:48 a.m., Resident 1's FM stated on 3/4/2026 she was in Resident 1's room in the dark when LVN 1 came in, put her hand under Resident 1's sheet, bent over and whispered something in Resident 1's ear, LVN 1 did not see her (FM) there. Later that night (time unknown), Resident 1 told her a nurse touched him inappropriately, when LVN 1 came back to the room, she asked Resident 1 if LVN 1 was the one who touched him inappropriately, he said yes. The FM stated she used a letter board (alphabets used to spell out words) to communicate with Resident 1, when Resident 1 reported this to her, she reported the allegation to LVN 2, who told her he would report it to RN 1. During a telephone interview on 3/6/2026 at 12:45 p.m., LVN 1 stated during the beginning of the shift 11 p.m. to 7 a.m., (3/4/2026), she went to Resident 1's room to see if Resident 1 was cold and Resident 1's FM yelled at her to get out. LVN 1 stated she reported to RN 1 what the FM said to her and LVN 3 removed her from the assignment caring for Resident 1. During a telephone interview on 3/6/2026 at 1:12 p.m., RN 1 stated on 3/4/2026 at 11:15 p.m., Resident 1's FM told her she did not want LVN 1 to take care of Resident 1 because (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 1 stressed Resident 1 out. Later during the shift at approximately 2 a.m., Resident 1's FM told her LVN 1 touched Resident 1's private area inappropriately, so she moved LVN 1 to a different assignment. RN 1 stated she knew the policy on abuse, and she should have sent LVN 1 home to protect Resident 1 and other residents pending an investigation. During an interview on 3/9/2026 at 11:30 a.m., the DON stated when there was an allegation of abuse against a facility staff, the staff should be suspended immediately because we do not want to put other residents at risk while we investigate the complaint. During an interview on 3/10/2026 at 2:46 p.m., the Administrator (ADM) stated when there was an allegation of abuse against a staff, the staff should be suspended until an investigation was completed. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Neglect Exploitation or Misappropriation - Reporting and Investigating revised 9/2022, the P&P indicated upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of an unknown source, the administrator is responsible in determining what actions (if any) are needed for the protection of residents. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to immediately report an allegation of abuse for two of three sampled residents (Resident 1 and Resident 2) when: 1. Certified Nursing Assistant (CNA) 1 reported to Licensed Vocational Nurse (LVN) 3 that Resident 2 accused her of abuse on 3/1/2026 and Resident 2 reported to her that CNA 1 twisted her (Resident 2) arm on 3/2/2026 but LVN 3 did not report the allegation of abuse to the Administrator (ADM), who is the facility's abuse coordinator. 2. Registered Nurse (RN) 1 was made aware of an allegation that LVN 1 inappropriately touched Resident 1 on 3/4/2026 but she did not report the allegation of abuse to the ADM. These practices resulted in the ADM, who was the facility's abuse coordinator, not knowing about the allegations of abuse made against CNA 1 and LVN 1, and the CDPH's inability to investigate the allegations of abuse in a timely manner. These deficient practices had the potential for information pertinent to the investigation to be lost and/or forgotten. Findings: a. During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 2 had diagnoses including primary essential hypertension ([HTN] high blood pressure), peripheral vascular disease ([PVD] a slow progressive narrowing of the blood flow to the arms and legs), and hypothyroidism (a deficiency of the hormone causing the body to slow down). During a review of Resident 2's Minimum Data Set Assessment ([MDS] a resident assessment tool) dated 2/4/2026, the MDS indicated Resident 2's cognition (ability to think and reason) was intact. Resident 2 required set up or clean up assistance to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) During a review of Resident 2's Change of Condition (COC)/Interact Assessment form ([SBAR] situation, background, assessment, recommendation, a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/2/2026 and timed at 1 p.m., the COC/SBAR indicated Resident 2 reported CNA 1 was rough with her, grabbed her wrist and twisted her arm, so she (Resident 2) tried to kick CNA 1 to get away from her. During an interview on 3/9/2026 at 9:56 a.m., Resident 2 stated, via CNA 1, who translated for Resident 2, on 3/1/2026 (time unknown) she was in bed and CNA 1 came to her room in a bad mood, grabbed her left arm tight and pressed her fingers into her left ankle hard. Resident 2 stated she did not think to tell anyone. During an interview on 3/9/2026 at 12 p.m., CNA 1 stated on 3/1/2026 she went into Resident 2's room to change her adult brief. Resident 2 was in bed, and she (CNA 1) rolled her from left to right while putting the adult brief on her. Resident 2 got upset and accused her (CNA 1) of grabbing her left arm and abusing her. CNA 1 stated she left the room and told LVN 3 that Resident 2 accused her of abuse. During an interview on 3/9/2026 at 12:17 p.m., CNA 2 stated she worked with CNA 1 on 3/1/2026 when Resident 2 accused her (CNA 1) of abuse. CNA 2 stated she was standing with CNA 1 when CNA 1 reported the allegation of abuse made by Resident 2 to LVN 3. During an interview on 3/9/2026 at 12:30 p.m., LVN 3 stated CNA 1 told her on 3/1/2026 that Resident 2 called her the B word and that Resident 2 was being aggressive towards her (CNA 1). LVN 3 stated she told RN 2 what Resident 1 reported to her and was told by RN 3 to change CNA 1's assignment. On 3/2/2026 (time unknown) Resident 2 told her that CNA 1 twisted her left arm on 3/1/2026 and she LVN 3) reported this allegation to the Administrator (ADM) 3/2/2026. b. During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1 had diagnoses including aphasia (a disorder that makes it difficult to speak) following a cerebral infarction (where blood flow to the brain has been blocked). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1's cognition was severely impaired. Resident 1 was dependent (helper does all the effort) on staff to complete his ADLs. During a review of Resident 1's COC/SBAR dated 3/5/2026 and timed at 11:58 a.m., the COC/SBAR indicated during the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interdisciplinary Team meeting ([IDT] a group of health care professionals with various areas of expertise who work together toward the goals of the residents) Resident 1's Family Member (FM) accused LVN 1 of lifting Resident 1's sheet, touching Resident 1's diaper, then LVN 1 placed the sheet back over Resident 1 and walked out of the room during the 11: p.m. - 7 a.m. shift on 3/4/2026. During an interview on 3/6/2026 at 10:48 a.m., Resident 1's FM stated on 3/4/2026 she was in Resident 1's room in the dark when LVN 1 came in, put her hand under Resident 1's sheet, bent over and whispered something in Resident 1's ear, LVN 1 did not see her (FM) there. Later that night (time unknown), Resident 1 told her a nurse touched him inappropriately, when LVN 1 came back to the room, she asked Resident 1 if LVN 1 was the one who touched him inappropriately, he said yes. The FM stated she used a letter board (alphabets used to spell out words) to communicate with Resident 1, when Resident 1 reported this to her, she reported the allegation to LVN 2, who told her he would report it to RN 1. During a telephone interview on 3/6/2026 at 12:45 p.m., LVN 1 stated during the beginning of the shift 11 p.m. to 7 a.m., (3/4/2026), she went to Resident 1's room to see if Resident 1 was cold and Resident 1's FM yelled at her to get out. LVN 1 stated she reported to RN 1 what the FM said to her. During a telephone interview on 3/6/2026 at 1:12 p.m., RN 1 stated on 3/4/2026 at 11:15 p.m., Resident 1's FM told her she did not want LVN 1 to take care of Resident 1 because LVN 1 stressed Resident 1 out. Later during the shift at approximately 2 a.m., Resident 1's FM told her that LVN 1 touched Resident 1's private area inappropriately. RN 1 stated she called the Director of Nursing on 3/5/2026 (time unknown) but did not get an answer back and did not report this to the DON. During an interview on 3/10/2026 at 2:46 p.m., the ADM stated he was never notified of the abuse allegation made by Resident 1's FM on 3/4/2026 until 3/5/2026 during an IDT meeting with the family. The Administrator stated he was not aware of Resident 2's allegation of abuse on 3/1/2026 until 3/2/2026. The ADM stated staff should notify him of any allegation of abuse immediately. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Neglect Exploitation or Misappropriation - Reporting and Investigating revised 9/2022, the P&P indicated if resident abuse, neglect, exploitation, misappropriation of resident's property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as within two hours of an allegation involving abuse or resulting in serious bodily injury; or within 24 hours if an allegation that does not involve abuse or results in serious bodily injury.